it is generally recommended when the prick test is negative or borderline reactive.[1] Moreover, intradermal tests do correlate significantly with bronchial and nasal allergen challenges.[2,3]

The subjects selected for our study were judged atopic on the basis of historical and physical findings of atopic disease; a history relevant to one or more of the allergens tested; and a positive prick or intradermal reaction to one or more of the panel of allergens. The skin tests were used as the benchmark for comparison with the new dipstick test for serum IgE antibodies and to a commercial radioallergosorbent test, which also measures serum IgE antibodies. Negative control subjects had been studied in a previous investigation and were not part of this study.

Most of Dr Marinkovich's remaining remarks focus on the indications for in vivo versus in vitro allergy testing, a topic of vigorous current debate. There are merits and shortcomings of each method. Unfortunately, because of the perceived commercial market for such tests, scientific discussion has been hampered by threats of litigation and other coercions.

The diagnostic test we studied was designed as a screening test for physicians not trained to treat allergic diseases and who feel the need for such a laboratory test. Some experts in the field deplore the use of screening tests and suggest more reliance be placed on a good history and physical examination.

The referral to an allergist may be self-serving, but it at least equally serves the patient. "Allergist" was used in the generic sense of any physician who is qualified to select appropriate allergens for testing, understands the merits and pitfalls of the various tests, can interpret the results and determine the applicability, and can provide an individualized plan of environmental controls and immunotherapy. Such a physician would also acknowledge the danger to a patient of the use of an in vitro test alone to institute antiallergy injections.

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Physician Payment Reform

To THE EDITOR: It is most disconcerting to note that neither the Physician Payment Review Commission nor Dr Lee mentions the necessity of reform of professional liability tort litigation as a vital accompaniment of Medicare—or any other—payment reform.[1]

Perhaps for those who are isolated from clinical medicine, the problem is a quaint abstraction whose surface costs—premiums and defensive medicine—can continue to be passed on to the medical care provider. Ultimately, however, the patient—"consumer" in bureaucratic dialect—will shoulder the brunt of the declining quantity and quality of medical school enrollees, technologic retreats, and pharmaceutical research and marketing cutbacks.

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Dr Lee Responds

To THE EDITOR: Apparently Dr Levine missed a very important point made in my article with respect to malpractice liability. In order to highlight the issue for the Congress, the Physician Payment Review Commission recommended a separate cost factor for professional liability, and the Congress adopted this recommendation. In addition, the commission has already studied the relationship between practice guidelines and malpractice and this year will be considering broader issues in tort reform. It also should be noted that there are six physician members of the Physician Payment Review Commission. We consider the liability problem to be of major importance and would welcome any suggestions Dr Levine might have regarding the issue.

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